Texas Heart®
Medical Group
6624 Fannin, Suite 2780 • Houston, Texas 77030 • (713) 790-9401

PATIENT FINANCIAL RESPONSIBILITY CONTRACT

(PLEASE PRINT)

Patient's Name: ________________________ Date of Birth: ______________ Account: ______________

- Thank you for choosing Texas Heart Medical Group (THMG) as your health care provider. We are committed to providing high quality care and service to our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.
- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash (U.S. Dollars), check, credit cards, debit cards and pre-approved insurance, for which we are a contracted provider.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage prior to treatment. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility.
- If you do not have insurance, you will be expected to pay for all services rendered on the day of your visit.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered on the day of your visit. We will provide you with a statment that you can submit to your insurance company for reimbursement, if applicable.
- Proof of payment method and photo ID are required for all patients. If you have insurance, we will as to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.
- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.
- Cash (U.S. Dollars), check, credit cards and debit cards are acceptable forms of payment for services. If fees are incurred related to checks returned for non-sufficient funds, you will be expected to pay such fees.
- Your signature below authorizes the release of medical information necessary to file claims with insurance payers. All other requests for medical records must be authorized by myself in writing.

I have read the patient financial responsibilities presented above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

______________________________ ______________________

Signature of Patient/Responsible Party   Date

______________________________ ______________________

Name of Patient/Responsible Party (please print)   Relationship to Patient